APPENDIX A

GLOSSARY AND COMMON ACRONYMS

Glossary

Activities of **D**aily **L**iving	**ADL**	Activities of daily living are those needed for self-care: bathing, dressing, mobility, toileting, eating, and transferring. The late-loss ADLs (eating, toileting, bed mobility, and transferring) are used in classifying a patient into a RUG-III group.
Assessment Period		The time period during which the assessment coordinator starts the assessment until it is signed as complete.
Assessment **R**eference **D**ate	**ARD**	The last day of the observation period for the MDS assessment. All MDS items refer back in time from this common endpoint. May also be referred to as the "Target Date" in CMS system-generated reports. The MDS field name is A3a.
Assessment Window		The period of time defined by Medicare regulations that specify when the Assessment Reference Date must be set. For example, the assessment window for a Medicare 5-Day assessment is between days 1-8, including grace days.
Browser		A program, such as Internet Explorer or Netscape, that allows access to the internet or a private intranet site. A browser with 128-bit encryption is necessary to access the CMS intranet for data submission or report retrieval.
Case **M**ix **I**ndex	**CMI**	Weight or numeric score assigned to each RUG-III group that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
Case Mix Reimbursement System		A payment system that measures the intensity of care and services required for each resident, and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.

Center for **H**ealth **S**ystems **R**esearch and **A**nalysis, University of Wisconsin – Madison	**CHSRA**	Researchers, funded by CMS, who have developed and tested a set of indicators of quality care in nursing facilities and a quality monitoring system for using the indicators for internal and external quality review and improvement.
Centers for **M**edicare and **M**edicaid **S**ervices	**CMS**	Formerly known as HCFA, the Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.
CMS MDS 2.0 Data Collection System		Software and hardware that has been provided to each state by CMS to collect MDS information in a standardized method and format. Each state is then charged with administering and supporting the system.
Code of **F**ederal **R**egulations	**CFR**	A codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the Federal Government. The CFR is divided into 50 titles that represent broad areas subject to Federal regulation. Each title is divided into chapters that usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations to the CFR will be provided at the section level.
Cognitive **P**erformance **S**cale	**CPS**	The measure of cognitive status used in the MDS and in the RUG-III Classification system.
Comprehensive Assessment		Requires completion of the MDS and review of triggered RAPs, followed by development or review of the comprehensive care plan.
Data **A**ssessment and **Ve**rification	**DAVE**	A program administered by CMS designed to ensure accuracy of MDS data accomplished through data analysis, off-site review, on-site review and provider education.

Discharge		For the purposes of MDS and SB-MDS, a discharge is reported when a resident leaves the facility for more than 24 hours for other than a temporary home visit or therapeutic leave, or is admitted to the hospital.
Dually Certified Facilities		Nursing facilities that participate in both the Medicare and Medicaid programs.
Duplicate Assessment		A fatal record error that results from a resubmission of a record previously accepted into the State MDS database. A duplicate record is identified as having the same target date, reason for assessment, resident, and facility. This is the only fatal record error that does not require correction and resubmission.
Facility **ID**	**FACID**	The facility identification number is assigned to each nursing facility by the State agency. The FACID must be placed in the header record in each MDS file, and in the individual MDS and tracking form records. This normally is completed as a function within the facility's MDS data entry software.
Fatal File		An MDS file that has an error in the format and causes the entire file to be rejected. The individual records are not validated or stored in the database. The facility must contact its software support to resolve the problem with the submission file.
Fatal Record		An MDS record that has an error severe enough to result in record rejection. A fatal record is not saved in the CMS database. The facility must correct the error that caused the rejection and resubmit a corrected original record.
Federal Register		The official daily publication for rules, proposed rules and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration, and is available by subscription and on-line.

Final **V**alidation **R**eports	**FVR**	A report generated after the successful submission of MDS 2.0 assessment data. This report lists all of the residents for whom assessments have been submitted in a particular submission batch, and displays all errors and/or warnings that occurred during the validation process. A FVR with a submission type of "production" is a facility's documentation for successful file submission. An individual record listed on the FVR marked as "accepted" is documentation for successful record submission.
Fiscal **I**ntermediary	**FI**	An organization designated by CMS to process Medicare claims for payment that are submitted by a nursing facility.
F-Tag		Numerical designations for criteria reviewed during the nursing facility survey.
Grace Days		Additional days that may be added to the assessment window for Medicare assessments without incurring financial penalty. These may be used in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments.
Header		The first record in an MDS file submitted to the CMS MDS 2.0 Data Collection System. This record contains facility and software vendor information for the subsequent records within the file.
Healthcare **C**ommon **P**rocedure **C**oding **S**ystem	**HCPCS**	A uniform coding system that describes medical services, procedures, products and supplies. These codes are used primarily for billing.
Health **C**are **F**inance **A**dministration	**HCFA**	Former name for CMS, (see CMS).
Health **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996	**HIPAA**	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.

Health **I**nsurance **P**rospective **P**ayment **S**ystem	**HIPPS**	Billing codes used when submitting claims to the FI for Medicare payment.
Hierarchy		The ordering of groups within the RUG-III Classification system. A hierarchy begins with groups with the highest resource use and descends to those groups with the lowest resource use. The RUG-III Classification system has 7 hierarchical groups: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions.
Inactivation		A type of correction allowed under the MDS Correction Policy. When an invalid record has been accepted into the database, a correction record is submitted with inactivation selected as the type of correction.
Index Maximizing		The process of RUG-III Classification where the RUG-III category with the highest case mix index (CMI) is selected from all of the possible groups in which a resident's assessment is classified.
Initial **F**eedback **R**eport	**IFR**	The first report generated by the CMS MDS 2.0 Data Collection System after an MDS data file is electronically submitted. This report validates the file structure, provides the submission batch ID, and indicates whether the file has been accepted or rejected. If the file has been accepted, each record will go through the edit process and be reported on the final validation report. If the file is rejected, there will be no final validation report.
Internal Assessment ID		A sequential numeric identifier assigned to each record submitted to the CMS MDS 2.0 Data Collection System.
International **C**lassification of **D**iseases, **9**th Revision, **C**linical **M**odification	**ICD-9 CM**	Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.

Invalid Record As defined by the MDS Correction Policy, a record that was accepted into the CMS MDS 2.0 Data Collection System that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified, or the wrong reason for assessment, or submission of an inappropriate non-required record.

Login ID A State-assigned facility identifier required to access the CMS MDS 2.0 Data Collection System. This may or may not be the same as the Facility ID.

Look Back Period A period of time in the past 7, 14, or 30 days from the Assessment Reference Date that is used when completing certain sections of the MDS.

Major Error As defined by the MDS Correction Policy, an error in an MDS assessment where the resident's overall clinical status has been misrepresented, or the current care plan does not suit the resident's needs.

MDS Completion Date The date at which the RN assessment coordinator attests that all portions of the MDS have been completed. For MDS, this is the date at section R2b. For SB-MDS, this is the date at item 45.

Medicaid A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.

Medicare A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities.

Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices.

Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.

Medicare **D**ata **C**ommunications **N**etwork	**MDCN**	A secure dial-up connection through the AT&T Global Network that is used to transmit MDS data to the State repository. A user ID and password is issued and maintained by the MDCN Help Desk for each person who requires access to the CMS MDS intranet through this network.
Medicare **P**rospective Payment **A**ssessment **F**orm	**MPAF**	A shortened assessment form designed to reduce the burden of completing the full MDS assessment for Medicare-only assessments. The MPAF contains the items necessary for resident identification, RUG-III Classification, and quality indicator calculations.
Metropolitan **S**tatistical **A**rea	**MSA**	A statistical standard classification designated and defined by the Federal Office of Management and Budget following a set of official published standards. These urban areas are used to adjust the Federal Medicare rates to account for differences in area wage levels.
Minimum **D**ata **S**et	**MDS**	A core set of screening, clinical, and functional status elements, including common definitions and coding categories that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.
Modification		A type of correction allowed under the MDS Correction Policy. A modification is required when a valid MDS record has been **accepted** by the CMS MDS database, but the information in the record contains errors. A modification is not done when a record has been rejected.
National **D**rug **C**ode	**NDC**	A unique 10-digit number assigned to each drug product listed under Section 510 of the Federal Food, Drug and Cosmetic Act. The NDC code identifies the vendor, drug name, dosage, and form of the drug.
Nursing **F**acility	**NF**	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

OBRA Assessments		A term used when referring to assessments mandated by OBRA regulations. These are assessments completed to meet clinical requirements. The OBRA assessments are: Admission, Quarterly, Annual, Significant Change in Status, Significant Correction of Prior Full, and Significant Correction of Prior Quarterly. The tracking forms for discharge and reentry are also required under OBRA regulations.
Observation Period		The time period, ending with the Assessment Reference Date, which is used by all staff for gathering information for an MDS assessment.
Omnibus **B**udget **R**econciliation **A**ct of 1987	**OBRA '87**	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
Other **M**edicare **R**equired **A**ssessment	**OMRA**	An assessment required when a Medicare Part A resident that was in a RUG-III Rehabilitation Classification, continues to require skilled care after all therapy is discontinued. This assessment is to be done 8-10 days after the cessation of therapies in order to re-calculate the RUG Classification from a therapy RUG to a non-therapy group. An OMRA may also be used in the situation where a significant change in status occurs for a Medicare resident outside a Medicare assessment window. AA8b is coded 8 for these assessments.
Other **S**tate **R**equired **A**ssessment	**OSRA**	A specific assessment required by a state in addition to assessments required by OBRA regulation or for Medicare. These assessments are defined by State regulations and are usually used for State Medicaid reimbursement systems. AA8b is coded 6 for OSRA assessments.
Peer **R**eview **O**rganization	**PRO**	See QIO – Quality Improvement Organization
Post **A**cute **C**are	**PAC**	Refers to residents who are admitted to a facility following an acute care hospitalization. Their stay is usually of short duration, about 30 days or less.

Program Memos		Official agency transmittals used for communicating reminder items, request for action or information of a one time only, non-recurring nature. Program Memos can be found at the following web site: **http://www.hcfa.gov/pubforms/tranmit/memos/comm_date_dsc.htm**
Program Transmittal		Transmittal pages summarize the instructions to providers, emphasizing what has been changed, added or clarified. They provide background information that would be useful in implementing the instructions. Program Transmittals can be found at the following web site: **http://www.hcfa.gov/pubforms/transmit/transmittals/com_date_dsc.htm**
Prospective **P**ayment **S**ystem	**PPS**	A payment system, developed for Medicare skilled nursing facilities, which pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.
PPS Assessments		Those assessments required by Medicare Prospective Payment Regulations for residents in a Medicare Part A stay. Each Medicare assessment is classified into a RUG-III group based on the clinical resource needs as recorded on the MDS assessment and are used to determine the Medicare reimbursement rate. These assessments are performed in addition to those assessments required by OBRA regulations. PPS assessments are: 5-Day, 14-Day, 30-Day, 60-Day, 90-Day, OMRA and Return/Readmission.
Quality **I**mprovement and **E**valuation **S**ystem	**QIES**	The umbrella system that encompasses the MDS and SB-MDS system as well as other systems for survey and certification, and home health providers.
Quality **I**mprovement **O**rganization	**QIO**	A program administered by CMS that is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of fifty-three QIOs (formerly known as Peer Review Organizations or PRO) responsible for each US State, territory, and the District of Columbia. Their mission is to ensure the quality, effectiveness, efficiency, and economy of healthcare services provided to Medicare beneficiaries.

Quality **I**ndicators	**QI**	Developed as part of the CMS funded Multi-State Nursing Facility Case Mix and Quality Demonstration (NHCMQ) by the University of Wisconsin. The Quality Indicators represent common conditions and important aspects of care. QI reports reflect a measure of the prevalence or incidence of conditions based on MDS assessment data.
Quality Measures	**QM**	Information derived from MDS data that is available to the public as part of the Nursing Facility Quality Initiative. The Quality Measures are designed to provide consumers with additional information for them to make informed decisions about the quality of care in nursing facilities.
Record Type		A code submitted in the MDS and tracking form records used to identify certain combinations of reasons for assessment.
Reentry		When a resident returns to a facility following a temporary discharge (return anticipated), a reentry is reported to either the MDS or SB-MDS system.

Registered **N**urse **A**ssessment **C**oordinator	**RNAC**	An individual, licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, who is responsible for coordinating and certifying completion of the resident assessment.
Resident Assessment		A comprehensive, standardized evaluation of each resident's physical, mental, psychosocial and functional status conducted within 14 days of admission to a nursing facility, promptly after a significant change in a resident's status, and on an annual basis.
RAI Coordinator		A resource person, usually with a State agency, who can provide information regarding specific State RAI requirements and assistance in MDS or SB-MDS completion.
Resident **A**ssessment **I**nstrument	**RAI**	The designation for the complete resident assessment process mandated by CMS, including the comprehensive MDS, Resident Assessment Protocols (RAPs), and care planning decisions. The RAI helps facility staff gather definitive information on a resident's strengths and needs that must be addressed in an individualized care plan.
Resident **A**ssessment **P**rotocols	**RAPs**	A problem-oriented framework for organizing MDS information and additional clinically relevant information about an individual's health problems or functional status.
Resident **A**ssessment **V**alidation and **EN**try System	**RAVEN**	Data entry software supplied by CMS for nursing facilities to use to enter MDS assessment data.
Resident **A**ssessment **V**alidation and **EN**try System for **S**wing-**B**eds	**RAVEN-SB**	Data entry software supplied by CMS for swing-bed hospitals to use to enter MDS assessment data.
Resource Use		The measure of the number of minutes of care used to develop the classification system. Direct and indirect time is obtained from RNs, LPNs, nursing assistants, physical, occupational and speech therapists, social workers, and activity staff. An index score is created based on the amount of staff time, weighted by staff salary and benefits.

Resource **U**tilization **G**roup, Version III	**RUG-III**	A category-based classification system in which nursing facility residents classify into one of 44 or 34 RUG-III groups. Residents in each group utilize similar quantities and patterns of resource. Assignment of a resident to a RUG-III group is based on certain item responses on the MDS 2.0. Medicare uses the 44-group classification. Many State Medicaid programs use the 34-group classification.
Respite		Short-term, temporary care provided to residents to allow family members to take a break from the daily routine of care giving.
Significant **C**hange in **S**tatus **A**ssessment	**SCSA**	A comprehensive assessment required when there is a decline or improvement in a resident's status that a) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, b) impacts more than one area of the patient's health status, and c) requires interdisciplinary review and/or revision of the care plan.
Significant Correction Assessment		A comprehensive assessment that is required when a major error has been identified in a previous assessment and has not been corrected in a subsequent assessment.
Skilled **N**ursing **F**acility	**SNF**	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
State **O**perations **M**anual	**SOM**	A manual provided by CMS that contains guidelines for the survey process.
Submission **Req**uirement	**SUB_REQ**	A field in the MDS electronic record that identifies the authority for data collection. CMS has authority to collect assessments for all residents (regardless of their payer source) who reside in Medicare- and/or Medicaid- certified units. States may or may not have regulatory authority to collect assessments for residents in non-certified units.
Swing-**B**ed **MDS**	**SB-MDS**	MDS assessments completed by swing-bed hospitals for Medicare Prospective Payment.

System **O**f **R**ecords	**SOR**	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
Target Date		A term used in CMS system-generated reports. This date is the Assessment Reference Date for an assessment, date of discharge for a discharge, and date of reentry for a reentry.
Transfer		When a resident leaves a nursing facility either temporarily or permanently, and goes to another health care setting.
Triggers		Specific MDS item responses that indicate the presence of clinical factors that should be considered by the interdisciplinary team when making care planning decisions.
Utilization Guidelines		Comprehensive information for evaluating factors that may cause, contribute to, or exacerbate a triggered condition.
Validation Report		See FVR or Final Validation Report.
V Codes		A supplementary classification of ICD-9 codes used to describe the circumstances that influence a resident's health status and identify the reasons for medical visits resulting from circumstances other than a disease or injury.

Common Acronyms

ADLs	Activities of Daily Living
AHEs	Average Hourly Earnings
ARD	Assessment Reference Date
BBA-97	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999
BEA	(U.S) Bureau of Economic Analysis
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
BLS	(U.S.) Bureau of Labor Statistics
CAH	Critical Access Hospital
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendments (1998)
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapist Assistant
CPI	Consumer Price Index
CPI-U	Consumer Price Index for All Urban Consumers
CPT	(Physicians) Current Procedural Terminology
CWF	Common Working File
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOS	Dates of Service
ECI	Employment Cost Index
ESRD	End Stage Renal Disease
FI	Fiscal Intermediary
FMR	Focused Medial Review
FR	Final Rule
FY	Fiscal Year
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCFA Pub. 10	Hospital Manual
HCFA Pub. 12	Skilled Nursing Facility Manual
HCFA Pub. 7	State Operations Manual
HCFA Pub.13-3	Medicare Intermediary Manual, Claims Process, Part 3
HCPCS	Healthcare Common Procedure Coding System
HIPPS	Health Insurance PPS (Rate Codes)

ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification Revision
IFC	Interim Final Rule with Comment
LOA	Leave of Absence
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review (File)
MIM	Medicare Intermediary Manual
MPAF	Medicare Prospective Payment System Assessment Form
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Area
NCS	National Supplier Clearinghouse
NDM	National Data Mover
NECMA	New England Country Metropolitan Area
NSC	National Supplier Clearinghouse
OBRA	Omnibus Budget Reconciliation Act of 1987
OMB	Office of Management and Budget
OMRA	Other Medicare Required Assessment
OT	Occupational Therapy
PCE	Personal Care Expenditures
PIM	Program Integrity Manual
PM	Program Memorandum
POS	Point of Service
PPI	Producer Price Index
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PT	Physical Therapy
PTA	Physical Therapist Assistant
QIO	Quality Improvement Organization
RAI	Resident Assessment Instrument
RAPs	Resident Assessment Protocol (Guidelines)
RUG	Resource Utilization Group
SB-MDS	Swing Bed Minimum Data Set
SB-PPS	Swing Bed Prospective Payment System
SCSA	Significant Change in Status Assessment
SNF	Skilled Nursing Facility
SNF PPS	Skilled Nursing Facility Prospective Payment System
ST	Speech Therapy
STM	Staff Time Measure